



### Request for Reconsideration

**Instructions:** Please type or print. Leave the block empty if you cannot answer it.  
Take or mail to: CareSource Advantage, P.O Box 1947, Dayton, OH 45401

1. Member Name	2. Identification Number
3. Representative Name (if applicable): <input type="checkbox"/> Relative <input type="checkbox"/> Attorney <input type="checkbox"/> Other Person <input type="checkbox"/> Provider Filing	
4. <b>Please attach a copy of the notice(s) you received about your claim to this form.</b>	5. Social Security Number _____ - _____ - _____
6. This claim is for: <input type="checkbox"/> Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Emergency Room <input type="checkbox"/> Home Health Agency (HHA) <input type="checkbox"/> Other	
7. Name of Provider (Physician, Hospital, SNF)	Provider Address, City & State
8. Date of Admission or Start of Services	9. Date(s) of the Notice(s) you received
10. I do not agree with the determination on my claim. Please reconsider my claim because: _____ _____ _____	
11. <b>You must obtain any evidence you wish to submit.</b> (Example: A letter from a doctor.) <input type="checkbox"/> I have attached the following evidence:  <input type="checkbox"/> I will send the evidence within 10 days.  <input type="checkbox"/> I have no additional evidence or information.	12. Only one signature is needed. Signed by:  <input type="checkbox"/> Member <input type="checkbox"/> Representative* <input type="checkbox"/> Provider Rep  <b>Sign Here</b> _____ <b>*If representative authorization needed</b>
13. Is this request filed within 60 days of your notice?  <input type="checkbox"/> Yes <input type="checkbox"/> No  If you checked "No", please attach an explanation.	14. Street Address: _____ City, State Zip Code _____  Phone: _____ <b>Date:</b> _____
15. If this request is signed by mark (X), TWO WITNESSES who know the person requesting the reconsideration must sign in the space provided. <b>Witnesses are ONLY required if this request has been signed by a mark (X).</b>	
Witness #1    _____ Address        _____ City, State Zip    _____	Witness #2    _____ Address        _____ City, State Zip    _____
<b>DO NOT FILL IN BELOW THIS LINE, THANK YOU</b>	
16. Routing	18. Date Stamp
17. Additional Information	